

Anthem Blue Cross and Blue Shield

Anthem Bronze GuidedAccess Plus - gjqa

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: Individual + Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling (855) 748-1805.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$5,000 person / \$10,000 family for In-Network Provider. Does not apply to Copayments, Prescription Drugs, and Preventive Care	You must pay all costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; \$6,350 person / \$12,700 family for In-Network Provider.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance-Billed charges, Health Care This Plan Doesn't Cover, and Costs related to Covered Prescription Drugs.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No; This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes; See www.anthem.com or call (855) 748-1805 for a list of	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or

Questions: Call (855) 748-1805 or visit us at www.anthem.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 748-1805 to request a copy.

Important Questions	Answers	Why this Matters:
	participating providers.	participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 3 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	YES, you need written approval to see a specialist. There may Be some providers or services for which referrals are not required. Please see the formal contract of coverage for details.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network provider** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 copay for first 3 visits and then 30% coinsurance	Not covered	Copay applies to the first three office visits, then deductible and coinsurance apply.
	Specialist visit	\$35 copay for first 3 visits and then 30% coinsurance	Not covered	Copay applies to the first three office visits, then deductible and coinsurance apply
	Other practitioner office visit	<u>Chiropractor</u> \$35 copay for first 3 visits and then 30% coinsurance <u>Acupuncturist</u> Not covered	<u>Chiropractor</u> Not covered <u>Acupuncturist</u> Not covered	<u>Chiropractor</u> Copay applies to the first three office visits, then deductible and coinsurance apply <u>Acupuncturist</u> -----none-----
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab - Office</u> 30% coinsurance <u>X-Ray – Office</u> 30% coinsurance	<u>Lab - Office</u> Not covered <u>X-Ray – Office</u> Not covered	<u>Lab - Office</u> Costs may vary by site of service. You should refer to your formal contract of coverage for details. <u>X-Ray – Office</u> Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Costs may vary by site of service. You should refer to your formal

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	\$15 copay per prescription for a 30 day supply and \$38 copay per prescription for a 90 day supply	Not covered	contract of coverage for details. \$6350 annual Out of Pocket limit per member for all covered prescription drug expenses. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).
	Tier 2 - Typically Preferred/Formulary Brand	\$35 copay per prescription for a 30 day supply and \$88 copay per prescription for a 90 day supply	Not covered	\$6350 annual Out of Pocket limit per member for all covered prescription drug expenses. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).
	Tier 3 – Typically Non-preferred/Non-formulary and Specialty Drugs	\$70 copay or 30% coinsurance, whichever is greater up to \$500 per prescription for a 30 day supply and \$175 copay or 30% coinsurance, whichever is greater up to \$1,250 per prescription for a 90 day supply.	Not covered	\$6350 annual Out of Pocket limit per member for all covered prescription drug expenses. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).
	Tier 4 -Typically Specialty Drugs	\$70 copay or 30% coinsurance, whichever is greater up to \$500 per prescription for a 30 day supply and \$175 copay or 30% coinsurance, whichever is greater up to \$1,250 per	Not covered	\$6350 annual Out of Pocket limit per member for all covered prescription drug expenses. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order or retail program).

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		prescription for a 90 day supply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay and then 30% coinsurance	Not covered	You should refer to your formal contract of coverage for details.
	Physician/surgeon fees	30% coinsurance	Not covered	You should refer to your formal contract of coverage for details.
If you need immediate medical attention	Emergency room services	\$250 copay and then 30% coinsurance	\$250 copay and then 30% coinsurance	Copay waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	-----none-----
	Urgent care	30% coinsurance	30% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay and then 30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	30% coinsurance	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> \$35 copay for first 3 visits and then 30% coinsurance <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> \$250 copay and then 30% coinsurance	<u>Mental/Behavioral Health Office Visit</u> Not covered <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> Not covered	<u>Mental/Behavioral Health Office Visit</u> -----none----- <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Mental/Behavioral health inpatient services	30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	<u>Substance Abuse Office Visit</u>	<u>Substance Abuse Office Visit</u>	<u>Substance Abuse Office Visit</u>

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		\$35 copay for first 3 visits and then 30% coinsurance <u>Substance Abuse Facility Visit - Facility Charges</u> \$35 copay and then 30% coinsurance	Not covered <u>Substance Abuse Facility Visit - Facility Charges</u> Not covered	-----none----- <u>Substance Abuse Facility Visit - Facility Charges</u> Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder inpatient services	\$500 copay and then 30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	\$500 copay and then 30% coinsurance	Not covered	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	-----none-----
	Rehabilitation services	\$35 copay for the first 3 visits and then 30% coinsurance	Not covered	Coverage for speech therapy is limited to 20 visits per calendar year, physical therapy is limited to 20 visits per calendar year, and occupational therapy is limited to 20 visits per calendar year. In-Network. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	\$35 copay for the first 3 visits and then 30% coinsurance	Not covered	Apply to In-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details. Habilitation and Rehabilitation visits count towards your

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				Rehabilitation limit.
	Skilled nursing care	\$500 copay then 30% coinsurance	Not covered	Coverage is limited to 100 days per calendar year. Apply to In-Network Providers. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Durable medical equipment	30% coinsurance	Not covered	-----none-----
	Hospice service	0% coinsurance	Not covered	-----none-----
If your child needs dental or eye care	Eye exam	No charge	Total cost less \$30 Reimbursement.	Coverage is limited to 1 exam every benefit period/12 months. \$30 maximum benefit per visit if use a Non-Network Provider.
	Glasses	No charge	Total cost less \$45 Reimbursement for frames and \$25 Reimbursement for Single lenses, \$40 Reimbursement for bifocal lenses and \$55 Reimbursement for trifocal lenses.	Coverage is limited to 1 set of glasses every benefit period/12 months.
	Dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 748-1805. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 518
North Haven, CT 06473-0518

Department of Labor's Employee
Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform

New Hampshire Insurance
Department
21 So Fruit St
Suite 14
Concord NH 03301
(800) 852-3416

Additionally, a consumer assistance
program can help you file your
appeal. Contact
New Hampshire Department of
Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(800) 852-3416
www.nh.gov/insurance
consumerservices@ins.nh.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagúí bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halné'ígúí ní béesh bee hane'í wólta' bi'ki si'niilígúí bi'kéhgo bich'í hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card..

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$1,500
- Patient pays \$6,000

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$5,000
Copays	\$500
Coinsurance	\$500
Limits or exclusions	\$0
Total	\$6,000

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: www.anthem.com or (855) 748-1805.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,700
- Patient pays \$1,720

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,100
Copays	\$400
Coinsurance	\$20
Limits or exclusions	\$200
Total	\$1,720

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com or (855) 748-1805.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co payments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call (855) 748-1805 or visit us at www.anthem.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 748-1805 to request a copy.

